SERI SUMMARY OF CHANGES (Ordered newest to oldest)

NOTE: Changes prior to 7/2013 are from previously published/formatted versions of the SERI and not included in this document.

May 30, 2014 - V201402.0 (July 1, 2014 effective)		
86	Special Program General Information	Added item 7 to clarify that ALL client encounters should be submitted (regardless of client registration in a program).
87	Evidence Based Practice – Children's Mental Health	Updated wording to clarify the requirements needed to submit services citing EBPs as indicated. Paragraph 2 has been changed from Activities to be reported using this process are related to services delivered to children. The programs associated with this effort are listed below. Definitions and reference material on these programs can be accessed through the Washington State Institute for Public Policy (WSIPP) website at http://www.wsipp.wa.gov/. *These programs are evidence and research based practices (E/RBP) that are delivered to the appropriate consumer population under guidelines defining the service delivery process. Only services that are delivered with adherence to the researched program model should be reported using this procedure.* To now read: Activities to be reported using this process are related to services delivered to children. The programs associated with this effort are listed below. Definitions and reference material on these programs can be accessed through the Washington State Institute for Public Policy (WSIPP) website at http://www.wsipp.wa.gov/. **Clinicians must have completed some formal training in the evidence based practice reported. Reporting these practices requires some foundation in the evidence and research based practices.**
Removed	Children's Evidence Based Practice – Thurston-Mason RSN	Removed Children's Evidence Based Practice (in the previous SERI version 201402.0 Pages 87/88) as it is no longer specific only to TMRSN.
93	PACT Program	Clarified the program inclusion section to correct an error. 3rd bulleted item previously read: Services provided by staff who not are members of a WA-PACT team are

		reported with the applicable CPT/HCPCS code and the modifier "UD". This should have read that Services provided by staff who ARE members should record with the UD modifier. **Word NOT removed.**
95/96	WISe Program	Added program description, definitions and information for the WISe program to be used by RSN's with WISe certified agencies.
101	Modifiers	Added High Intensity Treatment the list of modalities for the U8 modifier.
Removed	Program	Removed Multidimensional Therapeutic Foster Care (page 93 in the previous SERI 201401.0)program is discontinued.

January 2014 - V201402.0 (May 1, 2014 effective)		
22	S9480 (Intensive outpatient psychiatric services, per diem)	Returned to SERI for High Intensity. This was inadvertently left off prior publications.
57 100	Modifiers 52 and 53 (Reduced and Discontinued procedures)	Added Rehab Case Management as a valid service for these modifiers.
72	Engagement and Outreach	Clarified intention of service use.
89	Evidence Based Practices	Changed wording removing "fidelity" and "strict" in Program Description
102	WISe U8 modifier	Added U8 Modifier to numerous CPT/HCPCS codes. Defined parameters for use of the U8 modifiers.
NA	SERI update schedule	Future SERI updates will be published in January and July

July 2013 Changes

Please Note: Page numbers are omitted due to major formatting changes.
This is not an exhaustive list of changes rather a summary of major changes

	Item	Status/Change (July 2013)
	Allen/Marr Program	Removed
	Appendix A and B	Removed from document, changed format to add allowable codes, modifiers, provider types, unit/minute and service criteria information to each section.
	Item	**Status/Change (7/2013)**
	Brief Treatment Services (modifier UA)	Changed detail code information section of this modality to refer to Individual, Group and Family modalities for detail code information.
	Child and Family Team Meeting	Added clarification in notes regarding use of the service and the modifier. See other services description for clarification of use.
	Community Psychoeducation & Prevention Service	Removed. This service is intended to be provided to the general public and cannot be tracked in a client based encounter system.
	Community Transition	Removed as stand-alone item and included in the Jail Program section.
	Consultation codes 99241-99255	Removed from coverage by CMS per 2013 CPT manual.
	Co-occurring Treatment, Community Transition, Child & Family Team Meeting, Case Management (CIAP/ORSCP/DMIO); Engagement & Outreach, Interpreter Services, Involuntary Treatment Investigation, Mental Health Clubhouse, Request for Services, Respite Care Services, Sex Offender Treatment, Supported Employment, Telehealth, Testimony for Involuntary Treatment Services, Wraparound and Community Transition	Each of these removed from the modality section and moved to new 'Other Services' section of this document.

	Crisis Services	Corrected to remove UC modifier from Hotline service (staff safety not a factor on a phone call).
	Item	**Status/Change (7/2013)**
	Day Support Services	Updated notes to clarify use and how to record ancillary services.
	Formatting Changes	Added Modifiers in **Bold** if it is required for that service/modality in Table of Contents.
	Freestanding E&T	Removed provider type and clarified 837I submission does not include a provider type.
	Group Treatment	Removed 90857-Interactive Group Psychotherapy (deleted in 2013 CPT manual). Added add-on code 90785-Interactive Complexity which may be used with CPT 90853. See interactive complexity guidelines in the Introduction section for further information re: use of the Interactive Complexity add-on code.
	HCPCS code H0046	Added language to more clearly define and limit the expected use of this code as it appears in the individual treatment modality.
	High Intensity	Added clarification in Notes.
	Individual Modality	Added E/M Home visit codes 99347-99350.
	Intake Modality	Added link to RCW and WAC for definition of Mental Health Professional Added E/M Home visit codes 99341-99345.
	Integrated Substance Abuse Mental Health Assessment, Integrated Substance Abuse Mental Health Screening,	Removed. Information re justification for removal may be found at the end of this document

	Item	Status/Change (7/2013)
	Interactive Complexity Reporting Guidelines	Inserted new section
	Involuntary Treatment Investigation.	Added link to updated December 2011 (current) DMHP protocols.
	Modifiers	Added (R) behind the modifier within modalities if required for the service submission.
	Provider Types	Removed MH Specialist (07) and DMHP (11) as provider types on services. See service section regarding requirements for Involuntary Treatment Investigation and Special Population Evaluation. Staff should report actual provider type. Provider type (14) Non-Certified Peer Counselor listed only in Peer Support Services and included Provider Type 06 DOH Credentialed Certified Peer Counselor in each modality where applicable. Note: DBHR will address amendments to the provider type list in the next data dictionary publication. Added table of provider types.
	Psychological Assessment	Updated allowed provider types to match intended definition (removed Bachelor, Bachelor w/Waiver and Master w/Exception for codes 96101, 96116, 96118)
	Rehab Case Management	Clarified usage of this modality within the Notes section. Added new modifier to identify the provision of an intake (U9-Rehab Case Management-Intake Service).
	Item	**Status/Change (7/2013)**
	Services that may be provided prior to intake.	Noted in **Bold** in every applicable modality or service section to indicate if the service may be provided prior to intake.

	Stabilization Services	Added Individual Treatment in the included ancillary services to provide continuity of care to support when provided by client's primary therapist. Changed reporting from per diem to per hour.
	Telehealth	Clarified that Clinical Nurse, Specialists, Clinical psychologists and clinical social workers are allowed users of these codes
	What encounters to report	Updated exclusion definition.
	Who is eligible to receive…	Removed the term "crisis" stabilization and changed to stabilization services
	Provider Type 13	Removed from Interpreter services and code table in the back of the document
	Provider Type 08-N/A	Removed from Sexual Offender Treatment Service
	Code 90889	Added back in to Individual Treatment Services
	Code 96102	Added (1 or more) in the Unit/Minutes Column
	Provider Type 14	Removed throughout the SERI except in Peer Support

	Item	Status/Change (7/2013)
	Provider Type 06	Removed from: Code H2011, H0030 in Crisis Services – Code H2033 in High Intensity Treatment – Code H0004, H0036, H2017 in Individual Treatment Services – Code S9484 in Stabilization Services – Code 90846, 90847, 90849, 90853, and H0004 in Co-Occurring Treatment Services – Code H2011 in Involuntary Treatment Investigation – Code 99075 in Testimony for Involuntary Treatment Services – Code H2033 in Children's EBP (TMRSN) Program – Code T1016, H2028 in ORCSP program -
Introduction: General Encounter Reporting Instructions	Number 3 Letter A	Added at the end of the sentence: "Unless otherwise specified in the current CPT or HCPCS Manual"
Interpreter Services	Provider Type	Provider Type 08-N/A was inadvertently removed. Provider Type 08-N/A was added back under this service.

	Item	Status/Change (7/2013)
	Code 90889	Changed from reporting as Units (UN) back to Minutes (MJ)
	Code 96120	Changed from reporting as Units (UN) back to Minutes (MJ)
All Pages -- Footer	Bottom of title page and Footer of each page	Updated Title page and each page footer to reflect SERI year/month/version (201308.4)

Justification for RSNs to cease reporting GAINS-SS activity as encounters

Proposal:

The SERI Workgroup recommends that RSNs and their providers cease reporting encounters that are solely related to the administration of the GAINS-SS screening and assessment tools; a state-funded service.

Background:

When state legislation started requiring RSNs and their contracted providers to give the 3-Scale GAINS-SS screening tool to all clients, DBHR also required the reporting of the scores. Further, RSNs were required to report the Quadrant scale determination made by the clinician who had evaluated the scale scores for a given client. Since DBHR did not have the staff time to develop a "native" transaction to capture that data, it was decided that the scores would be reported with an encounter. However, in order to report an encounter, 2 HCPCS codes had been designated with which to report those activities. H0001 (Alcohol and/or drug assessment) and H0002 (Behavioral health screening to determine eligibility for admission to treatment program). The 3 scale scores are reported via H0002 and the Quadrant score via H0001. Providers generally implemented this process by taking a minute off of a mental health screening or intake activity and reporting this minute as one of these HCPCS codes. However, clients typically were given the GAINS-SS screening as part of a paperwork packet and were asked to fill it out and turn it in to either office staff or the clinician who would perform the screening or intake. The reporting of an "encounter" with 1 minute or so duration was, from the beginning, not really reporting a service that the client was getting as much as it was simply a vehicle to get scores reported through the encounter submission process to the state.

Several years ago, DBHR IT staff developed the native transaction that is now used to report the 3 scale scores and the Quadrant score: the "Co-occurring Disorder " transaction (121.02). RSNs changed their processes and information systems and have been reporting these scores via this transaction. The data gets imported into DBHR's CIS system. However, the reporting of the encounters (which no longer contain the scores themselves) are required, by the SERI, to be reported to ProviderOne. This adds an administrative burden to clinicians, providers and RSNs, in how the GAINS-SS data is reported.

During development of the 2011 SERI, which occurred in 2010, Alice Huber, of DBHR, requested that RSNs continue to report these encounters. The reasoning was that there was information from CMS that indicated that these types of activities might become "billable" services when provided by CMHAs. There was discussion that continuing to collect these encounters might provide a baseline of data that could then be added to rate setting and reporting activities to fully describe the constellation of service provision to Medicaid clients.

Recommendation:

In the past 2 plus years since the publication of the 2011 SERI, DBHR has not provided any further information about whether CMS rules have changed as predicated. Given that the SERI workgroup is working on a new rewrite of the encounter reporting rules for all providers and RSNs, the workgroup suggests that "Integrated Substance Abuse Mental Health Screening" and "Integrated Substance Abuse Mental Health Assessment" "service" categories in the SERI be removed.

Predicated results of recommendation:

- ProviderOne and DBHR's CIS systems will cease to get encounters specifically for these activities. RSNs might still continue to report services directly provided to clients, using these codes
- GAINS-SS scale scores and Quadrant scores will continue to be reported to DHBR
- Reports can still be produced showing, with client-level detail if needed, the ratio of clients with the various Quadrant scores, compared to many measures still available in the state's data sets
- Providers and RSNs will get administrative relief from having to record these activities separately
- Screening and intakes reported as encounters will again show the true amount of minutes spent providing the service (in cases where the CPT code unit is reportable in minutes)

Stabilization Change Summary: (S9485)

The SERI Redesign Workgroup spent a considerable amount of time trying to define the 24 hour situation in Stabilization. It was discovered that the implementation of this varied widely across providers/RSNs.

One example is a client starting Stabilization at 10AM on day 1, spending all of the second day in stabilization, then leaving at 10AM on the 3rd day. Some providers were recording anything less than 24 hours as Crisis H2011. This would inflate the reporting of crisis hours rather than reporting these as Stabilization. A provider would report H2011 for 56 Units on Day 1 (14 hours/in 15 min units), S9485 for 1 (per diem) on Day 2 and H2011 for 40 Units on Day 3 (10 hours in 15 min units).

Further, some providers were using "residential" rules for census at midnight as the rule. Therefore they would report S9485 (per diem) on Day 1, S9485 (per diem) on Day 2 and would not report any service on day 3 (discharge date).

It was determined that it would be better to require providers to report the actual duration without any concerns about interpretation, to be able to clearly identify actual Stabilization time and to be able to look at the service modality "equally" across the state, therefore the SERI

workgroup recommended that providers only report this service using the S9484 per hour service. In the above example, the encounter data would show 14 units of S9484 on Day 1, 24 units of S9484 on Day 2 and 10 units of S9484 on Day 3.

To address the issue of a client who is in Stabilization and also meets with their assigned clinician or medical provider, the rules should be the same as those defined in the FAQ regarding Day Support: the recording Stabilization staff can do a single note for the stabilization service that day but the total duration should NOT include the time spent and recorded/encountered by other staff as defined in the SERI:

"The following additional services may also be reported the same days as stabilization when provided by a staff not assigned to provide stabilization services;

- Intake
- Involuntary Treatment Services
- Services after Intake: (Family Treatment, Medication Management, Peer Support, Psychological Assessment, Therapeutic Psychoeducation)

And in addition, in order to provide continuity of care in support of established client/therapist relationships and best practices; Individual Treatment Services may also be provided when provided by the client's primary clinician.

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